

U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 29 August 2006

CASE NO.: 2005-BLA-5061

In the Matter of:

S.P., Widow of
J.P.,
Claimant

v.

WESTMORELAND COAL COMPANY,
Employer

and

DIRECTOR, OFFICE OF WORKERS'
COMPENSATION PROGRAMS,
Party-in-Interest

Appearances:

John Cline, Esq.
For the Claimant

Christopher Hunter, Esq.
For the Employer

Before: RICHARD A. MORGAN
Administrative Law Judge

DECISION AND ORDER DENYING BENEFITS

This proceeding arises from a survivor's claim for benefits under the Black Lung Benefits Act, 30 U.S.C. § 901 *et seq.* ("Act"), September 17, 2003. The Act and implementing regulations, 20 C.F.R., parts 410, 718, and 727 ("Regulations"), provide compensation and other benefits to:

1. Living coal miners who are totally disabled due to pneumoconiosis and their dependents;

2. Surviving dependents of coal miner's whose death was due to pneumoconiosis; and
3. Surviving dependents of coal miners who were totally disabled due to pneumoconiosis at the time of their death.

The Act and Regulations define pneumoconiosis, "black lung disease," or "coal workers' pneumoconiosis" ("CWP")) as a chronic dust disease of the lungs and its sequelae, including respiratory and pulmonary impairments arising out of coal mine employment.

PROCEDURAL HISTORY

The Claimant, S.P., the surviving spouse of J.P., filed a survivor's claim for black lung benefits on September 17, 2003.¹ The District Director issued a proposed Decision and Order on July 6, 2004, finding that the miner had pneumoconiosis, that it arose out of his coal mine employment, and that his death was due to pneumoconiosis; therefore, benefits were awarded. (Director's Exhibit ("DX") 29). On July 8, 2004, the Employer contested that determination and requested a formal hearing. (DX 30). This case was referred to the Office of Administrative Law Judges by the Director, Office of Workers' Compensation Programs ("OWCP") for a formal hearing and was subsequently assigned to me.

On May 10, 2006, I held a hearing in Beckley, West Virginia at which the Claimant and Employer were represented by counsel. No appearance was entered for the Director, OWCP. The parties were afforded the full opportunity to present evidence and argument.

Director's exhibits ("DX") 3-14 and 16-40 were admitted into the record. DX 1 and 2, consisting of closed prior living miner's claims, are not admitted *in toto*. In *Church v. Kentland-Elkhorn Coal Corp.*, BRB No. 04-0617 BLA (Apr. 8, 2005)(unpub.), the Benefits Review Board ("BRB" or "Board") ruled that evidence from a living miner's claim is not automatically admitted into a subsequent survivor's claim in the absence of a designation by one of the parties. *Church*, slip op. at 5. Therefore, in this case, DX 1 and 2 are not automatically admitted in this survivor's claim.² Moreover, the Employer moved that the records of the two prior claims be admitted for good cause, arguing that those records were transferred from the District Director to OALJ and therefore the parties relied upon them. At the hearing, I denied this motion. (Transcript ("TR") 20-21). Therefore, save designations of specific items from each record, the evidence in the two prior living miner's claims is not admitted.

DX 15 is also not admitted. That exhibit contains the original autopsy report conducted by Dr. Fausto Imbing on October 21, 2002. Neither party has designated this report as either one of its allotted autopsy reports allowed in support of its affirmative case, or as rebuttal; moreover,

¹ The miner had filed two living miner's claims during his lifetime. The first (DX 1) resulted in a denial of benefits when, on July 16, 1992, the Benefits Review Board upheld the Administrative Law Judge's Decision and Order Denying Benefits. The second (DX 2) also resulted in a denial of benefits when the Administrative Law Judge issued a Decision and Order Denying Benefits dated June 12, 2002.

² Parties, however, may specifically designate items from these claims as evidence in the current claim. As detailed *infra*, both parties have done so with respect to certain pieces of evidence.

there is no regulatory authority for the Director to be the proponent of an autopsy report. Finally, absent submission by a party, § 725.421 does not authorize the District Director to transfer this type of evidence to the OALJ; therefore, it does not automatically become part of the record when the case is referred to this Court. However, as explained *infra*, records of hospitalization, admitted as DX 19, included the original autopsy report; therefore, this report is admitted as part of that exhibit.

Claimant's exhibits ("CX") 2-4 and 6-9 and Employer's Exhibits ("EX") 1, 2A, and 3-5 were admitted at the hearing.³ I withheld ruling on CX 1 pending a more detailed consideration. (TR 56). As indicated *infra*, CX 1 is not admitted. Additionally, the Employer designated two X-rays from the second closed living miner's claim, DX 2 at 511 and DX 2 at 497, as evidence in support of its affirmative case.

Interim benefits were paid by the Black Lung Disability Trust Fund beginning October 1, 2002, and continuing to the present, in the amount of \$823.50 per month with a lump sum payment of \$16,897.20 for the period of October, 2002 through January, 2004.

ISSUES

- I. Whether the miner has pneumoconiosis as defined by the Act and Regulations?
- II. Whether the miner's pneumoconiosis arose out of his coal mine employment?
- III. Whether the miner's death was due to pneumoconiosis?

FINDINGS OF FACT

I. Background

A. Survivorship

The parties agreed and I find that the Claimant is an eligible survivor of the decedent miner (TR 70).

B. Coal Miner

The parties agreed and I find that the Claimant's husband was a coal miner, within the meaning of § 402(d) of the Act and § 725.202 of the Regulations for 19 years. (TR 69).

³ The exhibit that the Employer originally designated as EX 2, an autopsy report in rebuttal of DX 15, was not admitted because the Claimant had not proffered DX 15. In its place, I conditionally admitted EX 2A, an autopsy report in rebuttal of the Claimant's affirmative autopsy evidence, to be submitted post-hearing. That report was received by this Court on May 30, 2006 and is therefore admitted.

C. Date of Filing

The Claimant filed her claim for benefits, under the Act, on September 17, 2003. (DX 4). The issue was not contested and I find none of the Act's filing time limitations are applicable; thus, the claim was timely filed.

D. Responsible Operator

Westmoreland Coal Co. is the last employer for whom the decedent miner worked a cumulative period of at least one year and is therefore properly designated as the responsible operator in this case under Subpart G, Part 725 of the Regulations. (DX 5).⁴

E. Dependents

The miner had two dependents, his wife and adult disabled son, for purposes of augmentation of benefits under the Act, until his death. (DX 4). The Employer initially contested the dependency of the adult disabled son for the purposes of augmentation. However, at the hearing, Employer indicated that it would stipulate to this point so long as the Claimant provided documentation of the adult disabled son's disability for the record. By correspondence to this Court received May 22, 2006, Claimant submitted documentation that the adult disabled son is legally blind. Therefore, I find the condition of the Employer's stipulation met; thus, I also find that the decedent miner had two dependents for the purposes of augmentation.

F. Personal, Employment, and Smoking History

The decedent miner was born on October 23, 1943. (DX 4). He married the Claimant on December 30, 1967. (TR 59). The decedent miner served in the Army, including service in Vietnam, from 1965-67. (TR 59-60). He worked in the coal mines both before and after his military service. (TR 59). His last coal mine position was that of a continuous miner operator. (DX 5). He last worked in the coal mines in 1985. The decedent miner died on October 20, 2002.

There is evidence of record that the decedent miner's disability is due in part to his history of cigarette smoking. The Claimant testified that her husband began smoking during his service in Vietnam. (TR 62). She did not testify to an exact amount of cigarette intake but stated it was "not a lot." (TR 62-63). She also testified that he quit smoking in 1993. (TR 63).

II. Medical Evidence

A. Chest X-rays⁵

The Claimant designated two X-ray readings, of X-rays taken March 11, 1998 and September 8, 1999, from the report of Dr. Michael Alexander, admitted together as CX 4, as its

⁴ Moreover, this issue has not been contested.

⁵ In the absence of evidence to the contrary, compliance with the requirements of Appendix A shall be presumed. 20 C.F.R. § 718.102.

two X-ray readings allowed in support of its affirmative case, pursuant to 20 C.F.R. § 725.414.⁶ Dr. Alexander has not provided, either in his report or on individual forms, the specific results of these two X-ray readings. Rather, he considered them collectively with a group of readings of X-rays taken between 1995 and 1999 and reported that this group demonstrates the existence of pneumoconiosis at the level 2/2, q/t. (CX 4).⁷

The Employer has offered two readings of an X-ray taken June 26, 2001 in support of its affirmative case and one rebuttal reading for each offered by the Claimant. The results of these readings which, unlike those offered by the Claimant, are reported individually, and summarized in the following table:

Exhibit Number	Dates: X-ray/ Reading	Reading Physician	Qualifications	Film Quality	ILO Classification	Interpretation or Impression
DX 2 at 511	6/26/01 10/4/01	Wheeler	B-reader Bd. certified			Negative
DX 2 at 487	6/26/01 10/18/01	Kim	B-reader Bd. certified			Negative
DX 2 at 954	3/11/98 10/12/98	Wiot	B-reader Bd. certified			Negative
DX 2 at 793	9/8/99 11/20/99	Spitz	B-reader Bd. certified			Negative

B. CT Scans

A CT scan falls into the “other means” category of § 718.304(a). A CT scan is a “computed tomography scan. Computed tomography involves the recording of ‘slices’ of the body with an X-ray scanner (CT scanner). These records are then integrated by computer to give a cross-sectional image. The technique produces an image of structures at a particular depth within the body, bringing them into sharp focus while deliberately blurring structures at other depths.” *See The Bantam Medical Dictionary*, 96, 437 (Rev. Ed. 1990).

In this case, the Claimant submitted two CT, scans read by Dr. Michael Alexander, who is Board-certified in Diagnostic and Nuclear Radiology. (CX 6). The CT scans are dated November 21, 1995 and August 28, 1996. Dr. Alexander reported his findings jointly in a report dated October 18, 2001. I admitted his CT findings as CX 6.

Dr. Alexander found these two CT scans jointly confirmed the presence of several 15 mm large opacities, bilateral chest pleural thickening, and some nodular subpleural densities. This may indicate round atelectasis or a necrobiotic rheumatoid lung nodule, but a biopsy would be necessary for confirmation. (CX 6).

⁶ Dr. Alexander is Board Certified in Radiology and a B-reader. (CX 7).

⁷ This group consisted of nine readings.

In rebuttal, the Employer submitted Dr. Paul Wheeler's reading of the November 21, 1995 CT scan and Dr. Jerome Wiot's reading of the August 28, 1996 CT scan. (DX 2).⁸ With respect to the former, Dr. Wheeler found a mass compatible with inflammatory disease, or a possible tumor, linear scarring and nodules, and calcified granulomata consistent with tuberculosis. Dr. Wheeler stated that the contrast of the CT left is not useful for a pneumoconiosis evaluation. (DX 2). With respect to the latter, Dr. Wiot, who offered his opinion of this CT scan collectively with that of another, found no evidence of CWP or asbestosis, but rather pleural plaques consistent with past history of asbestosis exposure. He also found a mass with characteristics consistent with rounded atelectasis. (DX 2).

C. Pulmonary Function Studies⁹

Pulmonary Function Studies ("PFS") are tests performed to measure the degree of impairment of pulmonary function. They range from simple tests of ventilation to very sophisticated examinations requiring complicated equipment. The most frequently performed tests measure forced vital capacity ("FVC"), forced expiratory volume ("FEV₁") and maximum voluntary ventilation. ("MVV").

The Claimant has submitted the results of two PFS tests in support of its affirmative case.¹⁰ The Employer has not submitted any PFS evidence. The results of the evidence submitted by the Claimant are summarized in the table below:

⁸ Both Drs. Wheeler and Wiot are Board-certified in Radiology.

⁹ § 718.103(a), which is effective for tests conducted after January 19, 2001 (*see* § 718.103(b)), provides, "Any report of pulmonary function tests submitted in connection with a claim for benefits shall record the results of flow versus volume ("flow volume loop")." In the case of a deceased miner, where no pulmonary function tests are in substantial compliance with paragraphs (a) and (b) and Appendix B, noncomplying tests may form the basis for a finding if, in the opinion of the adjudication officer, the tests demonstrate technically valid results with good cooperation of the miner. 20 C.F.R. § 718.103(c). In this case, although the two Pulmonary Function Studies were conducted prior to January 19, 2001, they both contain a flow volume loop. Therefore, it is not necessary to make the aforementioned finding.

¹⁰ On its Evidence Designation Form, the Claimant referenced a PFS test conducted during an OWCP evaluation in connection with the second living miner's claim. However, because the medical evidence from the past living miners claims is not automatically admitted in this claim, and the Claimant has already designated the maximum number of PFS results allowed under § 725.414, the results of the PFS test from the OWCP evaluation in the second living miner's claim are not admitted.

Physician Date Exhibit #	Age Height	FEV ₁	MVV	FVC	Tracings	Comprehension Cooperation	Qualifying ¹¹ Conforming ¹²	Doctor's Impression
Zaldivar* 5/10/89 DX 2	45 65"	Pre: 1.40 Post: 1.73	Pre: 48 Post: 64	Pre: 2.64 Post: 3.04	Yes		Pre: Yes Yes Post: Yes Yes	.
Zaldivar 9/8/99 DX 2	55 65"	Pre: .87 Post: 1.03	Pre: 38 Post: 43	Pre: 2.10 Post: 2.24	Yes		Pre: Yes Yes Post: Yes Yes	

*For each test, Dr. Zaldivar administered the PFS both before and after the application of bronchodilators.

For a miner whose height is 65 inches, § 718.204(b)(2)(i) requires and FEV₁ equal to or less than 1.90 for a male 45 years of age. If such an FEV₁ is shown, there must be in addition, an FVC equal to or less than 2.38, an MVV equal to or less than 76, or a ratio equal to or less than 55% when the results of the FEV₁ test are divided by the results of the FVC test. Because both the FEV₁ and MVV have produced qualifying results, both before and after the application of bronchodilators, the May 10, 1989 PFS is qualifying with respect to both administrations of the test.

For a miner whose height is 65 inches, § 718.204(b)(2)(i) requires an FEV₁ equal to or less than 1.74 for a male 55 years of age. If such an FEV₁ is shown, there must be in addition an FVC equal to or less than 2.20 or an MVV equal to or less than 69, or by the aforementioned ratio. Because both the FEV₁ and FVC have produced qualifying values for the pre-bronchodilator administration, and both the FEV₁ and MVV have produced qualifying values for

¹¹ A test "qualifies" if it yields values that are equal to or less than the applicable table values set forth in Appendices B and C of Part 718.

¹² A test "conforms" if it complies with applicable quality standards found in 20 C.F.R. § 718.103(b) and (c). See *Old Ben Coal Co. v. Battram*, 7 F.3d 1273, 1276 (7th Cir. 1993). For a discussion concerning the compliance of the tests submitted in this matter with these quality standards, see *supra*, note 7.

the post-bronchodilator administration, the September 8, 1999 test is qualifying with respect to both administrations of the test.

D. Arterial Blood Gas Studies

Neither party has offered any blood gas study evidence in support of its affirmative case. Moreover, because evidence from the past living miner's claims are not admitted absent a proffer by one of the parties, that evidence is not admitted in the current claim.

E. Autopsy Reports

20 C.F.R. § 725.414(a)(2)(i) and (3)(i), respectively, allow the Claimant and Employer to each submit one "report of an autopsy" in support of their affirmative cases. § 725.414(a)(2)(ii) and (3)(ii) then allow the parties to submit one physician's interpretation of each autopsy in rebuttal of the one submitted affirmatively by the opposing party.¹³ Finally, where an opposing party has offered such rebuttal, § 725.414(a)(2)(ii) and (3)(ii) allow the party affirmatively proffering the original evidence to offer an additional statement from the physician who originally administered it for purposes of rehabilitation.

The definition of "report of an autopsy" has endured a tortured recent history. In *Kalist v. Buckeye Coal Co.*, BRB No. 03-0743 BLA (July 23, 2004)(unpub.), the Board adopted the Director's position that only the original prosector's report may constitute a "report of autopsy." The Director, and correspondingly the Board, implied that, because 20 C.F.R. § 718.106(a) requires an autopsy to include gross macroscopic and microscopic descriptions, and only the prosector viewed the body, only his report may constitute an autopsy report under the Regulations.¹⁴ *Kalist*, slip op. at 3-4.

In *Ohler v. Island Creek Coal Co.*, ALJ Nos. 2005-BLA-46 & 2005-BLA-5686 (May 31, 2006), the Director reversed its position. It instead stated that a slide review by a pathologist who was not present at the autopsy may constitute an autopsy report under § 725.414. *Ohler*,

¹³ I note that § 725.414(a)(2)(ii) and (a)(3)(ii) present an internal inconsistency with respect to what type of autopsy evidence may be rebutted. Those provisions state that each party "shall be entitled to submit, in rebuttal...one physician's interpretation of each...autopsy...submitted by [the opposing party] *under paragraph [(a)(2)(i) or (a)(3)(i)] of this section...*" (emphasis added). Thus, on the one hand, this provision states that a party may rebut the opposing party's "autopsy" and, on the other hand, allows for rebuttal of an offering under (a)(2)(i) or (a)(3)(i), which refers to a "report of autopsy." Therefore, the provision is inconsistent as to whether rebuttal is only available if the opposing party offers the actual autopsy or a report of an autopsy. The legislative history rectifies the discrepancy. Indeed, the Drafter's Comments concerning rebuttal autopsy evidence specifically state that § 725.414(a)(2)(ii) and (a)(3)(ii) were revised "to allow each side to submit one report in rebuttal of an autopsy report...offered by the opposing side." Regulations Implementing the Federal Coal Mine Health and Safety Act of 1969, as Amended, 65 Fed. Reg. 245, 79991 (December 20, 2000)(to be codified at 20 C.F.R. pt. 718). Therefore, rebuttal is available when an opposing party submits a report of an autopsy, not merely the actual autopsy.

¹⁴ This conclusion of law constituted dicta in the case. Specifically, the Board was addressing the issue of the admissibility of a particular reviewing pathologist's report. The Employer argued that the report was inadmissible because it constituted a second autopsy report and was therefore in violation of the § 725.414 evidentiary limitations. The Board, however, found that report, which included both a review of autopsy slides and other medical data, to be admissible as a medical report. Therefore, the Board's opinion concerning the definition of "autopsy report" was superfluous as, irrespective of that definition, the report was admissible as a medical report.

slip op. at 11. The Director argued that if only the prosector's report constituted an autopsy report, "there would be no point in including autopsy reports in the evidentiary limitations because there would virtually always be only one." *Id.* The Director further reasoned that autopsy reports need not include the gross descriptions required by § 718.106; rather, only the report of the original prosector is subject to this requirement. (See Director's Letter, attached).

In *Ohler*, the Court agreed with the Director that a slide review conducted by a reviewing pathologist may constitute an "autopsy report" under § 725.414. The Court, however, imposed the § 718.106 gross description requirement on such reports, in addition to those submitted by the prosector. To that end, this Court found that such reports shall reflect a consideration of the prosector's gross descriptions.

In this case, I adhere to the Court's ruling in *Ohler* in admitting autopsy reports under § 725.414. I find the non-precedential opinion in *Kalist* to be unpersuasive. The Board's seeming reliance on § 718.106 does not foreclose the possibility that a reviewing pathologist may consider another physician's gross descriptions. Indeed, nothing in the language of § 718.106 requires that the doctor preparing the autopsy report rely on *his own* gross descriptions.

I further emphasize, contrary to the Director's position in *Ohler*, that the gross descriptions must be included in a slide review. Contrary to the Director's reading of the Regulation, § 718.106(a) specifically states that "A report of an autopsy...submitted in connection with a claim shall include a detailed gross macroscopic and microscopic description..." Therefore, the plain meaning of the Regulation imputes this requirement on all autopsy reports, not merely the reports of the prosector.¹⁵

Therefore, in sum, a review of pathology slides that also considers the gross macroscopic and microscopic descriptions of the lungs or visualized portions of the lungs constitutes an autopsy report under § 725.414.

In this case, although the original prosector's report has not been admitted as a proffered exhibit, it has been admitted as part of a record of hospitalization. Therefore, references in the autopsy reports to the gross macroscopic and microscopic descriptions of the lungs from the original report are admissible.¹⁶

Additionally, should a report consider both a review of pathologic slides and other medical evidence, it shall be considered a medical report.¹⁷ Such a report, however, may be considered an autopsy report provided that references to the additional medical evidence are redacted.

¹⁵ Legislative history also supports this position. The 1999 Drafter's Comments state that "a report of autopsy...must substantially comply with the applicable quality standards, § 718.106." Regulations Implementing the Federal Coal Mine Health and Safety Act of 1969, as Amended, 64 Fed. Reg. 54996 (October 8, 1999)(to be codified at 20 C.F.R. pt. 718).

¹⁶ This ruling is specifically in response to the Board's holding in *Dempsey v. Sewell Coal Co.*, 23 B.L.R. 1-47 (2004) that expert opinions must be based on admissible evidence. Additionally, had the prosector's report not been admissible, references to the gross descriptions in the autopsy reports would have been admitted for good cause.

¹⁷ The Board in *Kalist* and the Director and Court in *Ohler* all concur on this point.

In this case, the Claimant has submitted DX 18 and 21 jointly as its affirmative autopsy report.¹⁸ The Claimant has submitted CX 3 as an autopsy report in rebuttal of the Employer's affirmative autopsy report. The Employer has submitted EX 1 as its affirmative autopsy report.¹⁹ The Employer has also submitted CX 2A in rebuttal of the Claimant's affirmative autopsy report and EX 5 in rehabilitation of EX 1.²⁰

Dr. Jeffrey A. Kahn, who is Board-certified in anatomic and clinical pathology, issued DX 18 and DX 21 on August 16, 2003 and January 26, 2004, respectively. He reviewed the pathologic slides and the prosector's report in preparation. In DX 15, he diagnosed simple and mild CWP, bronchopneumonia, and pulmonary silicosis. With respect to CWP, Dr. Kahn found a few scattered small coal macules, which he stated are the "hallmark lesion of [CWP]," but no coal nodules. In DX 21, he diagnosed pulmonary emphysema, acute bronchopneumonia, silicosis, interstitial fibrosis, coal macules indicating CWP, and one coal nodule, indicating a more advanced stage of CWP. He further noted that the histologic slides did not indicate rheumatoid lung disease because of a lack of necrobiotic nodules or lymphoid hyperplasia. (DX 21).

Dr. Francis Green, who is Board-certified in Anatomic Pathology and a Professor of Pathology and Laboratory Medicine at the University of Calgary, issued an autopsy report dated April 12, 2006. (CX 3). In preparation, he reviewed the autopsy slides and considered the prosector's report and the September 18, 2004 report of Dr. Stephen A. Bush, admitted as EX 1.²¹ Dr. Green made the following diagnoses: coronary atherosclerosis, old myocardial infarction, simple CWP (comprising of macules, micronodules, and interstitial fibrosis), three lesions of progressive massive fibrosis (PMF), centriacinar emphysema, pulmonary vascular changes consistent with pulmonary hypertension, and focal bronchopneumonia. Dr. Green concluded that, based on the severity of these pathologic findings, both pneumoconiosis/silicosis and dust induced emphysema had an adverse effect on the decedent miner's lung function and contributed significantly to his respiratory failure.

Dr. Green stated that he agreed with Dr. Bush's diagnosis of CWP but disagreed with his characterization of the disease. Specifically, Dr. Bush found nodules measuring up to 0.8 cm in thickness, as well as smaller nodule, and termed this "mild" CWP. In Dr. Green's view, such a finding represents a greater than "mild" degree of CWP. To that end, Dr. Green noted that all of the lesions were greater than 1.0 cm in maximum dimension.

¹⁸ At the hearing, I ruled that DX 18 constituted a supplement to DX 15 and therefore both are admitted jointly as a single report. (TR 6-7). Additionally, DX 18 contains a review of medical information beyond the slide review and gross descriptions. For the purposes of considering this document as an autopsy report, only the review of slides and gross descriptions, and conclusions drawn therefrom will be considered.

¹⁹ EX 1 also contains a review of medical information beyond the slide review and gross descriptions. As is true for DX 21, only the review of slides and gross descriptions, and derivative conclusions, shall be considered for this exhibit as an autopsy report. As noted *infra*, the Employer also proffered this exhibit as a medical report and its entire review, and derivative conclusions shall be considered in that capacity.

²⁰ Again, as it relates to rehabilitation of EX 1 as an autopsy report, only the review of slides and gross descriptions in EX 5 shall be considered.

²¹ As stated, the Claimant offered Dr. Green's report in rebuttal of EX 1.

With respect to Caplan's disease, of which Dr. Bush found features suggestive, Dr. Green stated that the slides revealed some features of the disease but lacked its major characteristic-granulomatous inflammation.²² Therefore, Dr. Green stated that the lesions present more aptly represented PMF, not Caplan's disease; however, he stated that the distinction is unimportant as both represent a complicated form of pneumoconiosis or PMF.

With respect to rheumatoid arthritis, Dr. Green stated that if it played a role, it was to produce Caplan's disease, which he further explained is a form of PMF caused by exposure to coal mine dust in miner with rheumatoid arthritis.

Dr. Stephen T. Bush, who is Board-certified in anatomic and clinical pathology, submitted an autopsy report dated September 18, 2004. (EX 1). For its purposes as an autopsy report, Dr. Bush reviewed the autopsy slides and prosector's report.²³ Based on his slide review, Dr. Bush found lesions of pneumoconiosis, which constituted of a mild to moderate amount of dust pigment associated with a fibrous reaction. He also stated that most of the lesions have features suggestive of Caplan's disease and some show central ischemic degeneration and areas of calcification. Dr. Bush also found evidence of rheumatoid arthritis and rheumatoid lung disease not associated with dust pigment. Finally, Dr. Bush reported evidence of centrilobular emphysema and bronchopneumonia.

Dr. P. Raphael Caffrey, who is Board-certified in anatomic and clinical pathology, issued an autopsy report in rebuttal of DX 21 dated May 22, 2006. (EX 2A). In preparation, Dr. Caffrey reviewed the autopsy slides, the gross descriptions in the prosector's report, and Dr. Kahn's January 26, 2004 report.²⁴ Based on a review of slides, Dr. Caffrey diagnosed simple mild CWP, findings consistent with Caplan's disease (Caplan's pneumoconiosis), interstitial fibrosis, interstitial pneumitis, centrilobular emphysema, cardiomegaly, old myocardial infarction, and moderate coronary artery atherosclerosis. Dr. Caffrey also diagnosed lesions consistent with rheumatoid pneumoconiosis.

With respect to Dr. Kahn's opinion, Dr. Caffrey agreed that the miner had simple CWP. However, he questioned why Dr. Kahn did not include any diagnosis related to heart or coronary arteries, given his identification of several foci of scarring within the myocardium that represent areas of previous myocardial infarction. He also disputed Dr. Kahn's opinion that the miner did not exhibit rheumatoid lung disease.²⁵ Finally, Dr. Caffrey disagreed with Dr. Kahn's opinion that chronic obstructive pulmonary disease ("COPD") was due to mild CWP.

The Employer also submitted an April 29, 2006 report by Dr. Bush in rehabilitation, given the rebuttal autopsy evidence offered by the Claimant. (EX 5). § 725.414(a)(3)(ii) allows a responsible operator to submit an additional statement by the physician who originally

²² In contrast, Dr. Bush had found the presence of granulomatous inflammation.

²³ As stated, Dr. Bush reviewed additional medical information as well. His consideration of this information, and any derivative conclusions, are redacted for the purposes of this report as an autopsy report. Those references and conclusions, however, are allowed in consideration of this report as a medical report, *infra*.

²⁴ Dr. Caffrey also reviewed the entire prosector's report, the miner's occupational history, the death certificate, and various pieces of correspondence. However, because this is a rebuttal autopsy report, references to these additional documents, and derivative conclusions, are redacted.

²⁵ However, I note that Dr. Caffrey largely based this opinion on his consultation of additional medical evidence.

administered an objective test when the claimant submitted rebuttal evidence of that test. Here, the Claimant offered the report of Dr. Green in rebuttal to the autopsy report by Dr. Bush; therefore, the Employer is entitled to an additional statement by Dr. Bush. In preparation for this report, Dr. Bush reviewed the reports of Dr. Green and Dr. Cohen.²⁶

After reviewing Dr. Green's report, Dr. Bush's conclusions, as detailed above, remained unchanged. He first took issue with Dr. Green's diagnosis of progressive massive fibrosis due to insufficient measurements to support this opinion. He also took issue with Dr. Green's theoretical premise for discounting a discreet diagnosis of Caplan's disease. (EX 5).

Finally, the Claimant has proffered CX 1, a March 21, 2006 report by Dr. Kahn, as rehabilitative medical report. For the reasons explained *infra*, this document is not admitted for that purpose. Although the Claimant did not proffer it as such, I also decline to admit it as a rehabilitative autopsy report. § 725.414(a)(2)(ii) allows a claimant to submit an additional statement from the physician who originally "administered" the objective test when the responsible operator submits rebuttal evidence of that test. Dr. Kahn authored CX 1 in response to Dr. Bush's September 18, 2004 report, a report submitted affirmatively, not in rebuttal, by the Employer. To permit Dr. Kahn's additional statement would be tantamount to allowing a second rebuttal of Dr. Bush's autopsy report, not the rehabilitation that § 725.414(a)(2)(ii) contemplates. Therefore, it is not admitted for this purpose.

F. Physicians' Reports

A determination of the existence of pneumoconiosis may be made if a physician exercising sound medical judgment, notwithstanding a negative X-ray, finds that the miner suffers or suffered from pneumoconiosis. 20 C.F.R. § 718.202(a)(4).

In addition to submitting it as an autopsy report, the Claimant has offered Dr. Kahn's January 26, 2004 report as a medical report. (DX 21). For this purpose, all of the medical evidence Dr. Kahn considered, and all of his derivative conclusions, will be considered. In addition to the autopsy slides and prosector's report, Dr. Kahn considered the death certificate, several records of treatment and hospitalization, numerous reports of objective testing, numerous medical reports, the miner's employment history, and the 1983 findings of the Occupational Pneumoconiosis Board.²⁷

Based on this entire review, Dr. Kahn concluded that the miner had suffered pulmonary diseases that interacted and contributed to his disability. Based on his histological review, Dr. Kahn stated that these diseases included CWP, silicosis, bronchopneumonia, and pulmonary emphysema. He also diagnosed chronic bronchitis from a clinical standpoint. As stated above,

²⁶ For the purposes of this report as a rehabilitative autopsy report, Dr. Bush's consideration of Dr. Cohen's report is redacted as allowing it would be tantamount to rebuttal of that report, which would exceed the rehabilitative purpose.

²⁷ Because of the Board's holding in *Dempsey*, references to objective tests and medical reports other than those admitted in connection with this claim are redacted. With respect to medical reports, I note that the only one admitted in this claim that Dr. Kahn considered is Dr. Alexander's October 18, 2001 report.

Dr. Kahn found a diagnosis of rheumatoid lung disease to be unjustified because of a lack of histological evidence demonstrating as much. (DX 21).

With respect to causation of respiratory disability and death, Dr. Kahn stated that COPD, chronic bronchitis, pulmonary emphysema, silicosis, and CWP each produced adverse physiologic effects that aggravated the effects produced by one another, and that “the physiologic effects of these diseases combined in synergistic ways to make the effects of each entity much worse than a simple additive effect.” (DX 21 at 6). Thus, Dr. Kahn emphasized that CWP and silicosis were both present and contributed to the miner’s progressive disability and death. (DX 21).

Dr. Robert A.C. Cohen, who is Board-certified in Internal Medicine with a subspecialty in Pulmonary Disease, issued a medical report dated April 8, 2006. (CX 2). In preparation for this report, he reviewed his own examination report dated November 28, 2001, the miner’s occupational history, treatment records dated June, 2001-October, 2002, the death certificate, the prosecutor’s report, numerous medical reports, three PFS tests, three blood gas tests, and a cardiopulmonary stress test.²⁸

Based on this review, Dr. Cohen stated that the miner suffered from simple CWP. He based this conclusion primarily on the autopsy evidence. Dr. Cohen also disputed the opinions of Drs. Bush and Caffrey that the miner suffered from Caplan’s disease, due to a lack of palisading granulomatous peripheral change in the lesions.²⁹

With respect to causation, Dr. Cohen stated that CWP “almost certainly” contributed to the severe obstructive pulmonary disease and chronic respiratory failure that caused the miner’s death. He further explained that the miner’s obstructive impairment was caused by exposure to both coal mine dust and cigarette smoke. Dr. Cohen referenced unspecified studies, which state that when a coal miner or a long term smoker develops COPD, either of these two exposures is likely to be the cause. Moreover, the studies show that if an individual is exposed to both, the two exposures have an additive effect. Thus, in this miner’s case, Dr. Cohen characterized his exposures to both coal dust and cigarette smoke as “comparable and additive.” He further discounted rheumatoid lung disease because that is a restrictive process and the miner exhibited obstructive failure.

²⁸ Dr. Cohen’s reference to his own examination report, however, is admitted for good cause, as I admitted references to evidence from the living miner’s claim in Dr. Castle’s report. (TR 53). Therefore, I will also admit references to evidence from the living miner’s claims in Dr. Cohen’s report. Because Dr. Cohen authored his examination report in connection with the second living miner’s claim, I will allow the reference for good cause. His reference to the three PFS tests are admitted as the results of those tests were reported in the hospitalization records found at DX 19. The references to the blood-gas tests are redacted as none are admitted in the current claim and none were considered in a past living miner’s claim. Finally, references to Dr. Kahn’s March 21, 2006 report, Dr. Caffrey’s March 9, 2006 report, and Dr. Castle’s July 27, 2005 report are also redacted as none is admitted in connection with the current claim.

²⁹ Irrespective of this finding, Dr. Cohen noted that Caplan’s disease occurs among coal miners with rheumatoid arthritis and therefore is occupational in nature. Thus, according to Dr. Cohen, even if the miner had exhibited this disease, it would have arose out of coal dust exposure.

The Claimant has proffered CX 1, a statement by Dr. Kahn dated March 21, 2006, as a rehabilitative medical report pursuant to § 725.414(a)(2)(ii). This document, however, is not admitted for this purpose. § 725.414(a)(2)(ii) allows that, where rebuttal evidence tends to undermine the conclusions of a physician who prepares a medical report, that original physician may submit an additional statement explaining his conclusions in light of the rebuttal evidence. Here, CX 1 exclusively addresses the September 18, 2004 report of Dr. Bush, which was evidence offered by the Employer in support of its affirmative case. Therefore, Dr. Kahn has not authored this report in light of rebuttal evidence but rather in light of affirmative evidence. As such, it is not admitted as a rehabilitative medical report. Moreover, because the report does nothing more than address Dr. Bush's conclusions, I decline to admit it as supplemental to DX 21. Therefore, CX 1 is not admitted in the record.

I also admitted for good cause, the report of Dr. Michael Alexander dated October 18, 2001. (CX 7).³⁰ Dr. Alexander is Board-certified in Diagnostic Radiology, Nuclear Radiology, and Nuclear Medicine. In preparation for this report, Dr. Alexander considered twenty chest X-rays, which he classified into two groups: 1982-88 and 1995-99. He also reviewed two CT scans, dated November 21, 1995 and August 28, 1996.

In addition to his conclusions concerning the CT evidence detailed above, Dr. Alexander concluded that the first group of chest X-rays was collectively consistent with simple CWP, category p/q, 1/1. He concluded that the second group collectively demonstrated larger and more numerous small round and irregular opacities that he classified as q/t, 2/2. He also found evidence of interstitial fibrosis and emphysematous changes.

Taken in total, Dr. Alexander concluded that the miner had CWP at least at the level of p/q, 1/1 and moderate severe bilateral lung disease, comprised of various opacities, pleural thickening, probable interstitial fibrosis, and emphysema. With respect to causation of the miner's lifetime condition, Dr. Alexander attributed it to both CWP and rheumatoid lung disease. He did state, though, that if rheumatoid lung disease were present, it would mask and underestimate the proficiency of CWP. He characterized this case as "very complex" and could not apportion between the two processes he identified.

The Employer has proffered the entirety of Dr. Bush's September 18, 2004 report (EX 1) as a medical report. The Employer has also put forth EX 4 and 5 as supplemental to EX 1, in which Dr. Bush responds to Drs. Kahn, Green, and Cohen. For the same reasons that I declined to admit CX 1, I decline to admit these reports as supplements. Namely, these additional reports serve only to rebut the evidence they consider. Such rebuttal is not admissible under § 725.414.³¹ I will, however, allow EX 5 for the limited consideration of rehabilitation in light of Dr. Green's rebuttal autopsy evidence. As stated, § 725.414(a)(3)(ii) allows, where the

³⁰ This report existed in the second living miner's claim as DX 19. I found the good cause to be the fact that Dr. Alexander reviewed numerous objective tests and reported them collectively. The Claimant has relied on several of these tests; however, it is impossible to consider them individually because of Dr. Alexander's method of reporting. Therefore, to consider the objective evidence the Claimant has proffered, Dr. Alexander's entire report is necessary.

³¹ Specifically, the Employer has already submitted rebuttal of Dr. Kahn's report as an autopsy report and the Regulations do not permit rebuttal of a medical report. Therefore, no additional rebuttal is allowed because the exhibit has also been submitted as a medical report. Similarly, no rebuttal is allowed in response to the medical report of Dr. Cohen or the rebuttal autopsy report of Dr. Green.

claimant's rebuttal evidence undermined the conclusion in the medical report, the physician authoring a medical report may submit an additional statement in light of the rebuttal evidence. Here, Dr. Green's rebuttal autopsy evidence undermined the conclusions in Dr. Bush's medical report and, therefore, Dr. Bush is entitled to an additional statement in light of that rebuttal evidence.

As a medical report, Dr. Bush considered treatment records dated 1989-2002, and the death certificate, in addition to the slide review and prosector's report noted above. Based on this entire review, Dr. Bush diagnosed a mild degree of simple CWP and lesions suggestive of Caplan's disease. He also found evidence of centrilobular emphysema, bronchopneumonia, and rheumatoid lung disease.

With respect to causation, Dr. Bush stated that the miner's occupational disease was too limited to have contributed to death. He further opined that the miner suffered from severe respiratory impairment as a result of diffuse involvement of the lungs by changes of rheumatoid lung disease. Accordingly, he attributed the miner's respiratory failure and eventual death to interstitial disease resulting from rheumatoid disease.

The Employer has also put forth the April 4, 2006 report of Dr. James Castle, who is Board-certified in Internal Medicine with a subspecialty in Pulmonary Disease, issued a medical report dated April 4, 2006. (EX 3). In preparation for this report, Dr. Castle reviewed the miner's employment history, four scan readings, the results of three PFS tests, the results of one blood-gas study, numerous chest X-ray reports, various records of hospitalization and treatment, the death certificate, the prosector's report, and the opinions of Drs. Kahn and Bush.³²

Based on this review, Dr. Castle concluded that the miner had minimal simple CWP. He noted several risk factors for the development of the miner's pulmonary symptoms, including his coal mine employment, smoking history, cardiac disease, rheumatoid arthritis, and Caplan's disease. Dr. Castle also reported that the miner demonstrated evidence of an interstitial pulmonary process. He stated that the physiologic studies indicated that the miner had at least moderate airway obstruction, with at least some degree of reversibility, and some restrictive lung disease as well. Dr. Castle attributed these findings to smoke induced airway obstruction and restrictive lung disease due to rheumatoid lung disease. Dr. Castle believed that the miner was disabled from a respiratory standpoint prior to his death.

With respect to causation, Dr. Castle opined that the neither the miner's respiratory disability nor death was due to CWP. Rather, he attributed his disability to tobacco smoke induced airway disease and rheumatoid lung disease. He further stated that the miner was disabled as a whole man due to rheumatoid arthritis, coronary artery disease, non-insulin dependent diabetes, and tobacco smoke induced airway disease. Finally, he attributed death to bronchopneumonia occurring in a setting of an individual with severe rheumatoid lung disease and tobacco smoke induced pulmonary emphysema. CWP, according to Dr. Castle, played no role in the miner's death.

³² Dr. Castle has referenced a plethora of objective medical from the past living miner's claims. Because this evidence is not admitted in the current survivor's claim, references to it would typically be redacted. However, I admitted these references for good cause as they were central to Dr. Castle reaching his conclusions. (TR 53).

III. Witness Testimony

The Claimant testified that her husband was exposed to considerable amounts of coal dust in his work. (TR 60-61). She first started noticing his shortness of breath around 1980 when he started having trouble walking long distances. (TR 61). She further testified that his breathing got worse after he left the mines. (TR 61). He eventually required oxygen in increasing amounts. (TR 61). She explained how his breath deteriorated to the point that he was virtually incapacitated at home. (TR 62).

With respect to smoking, the Claimant testified that her husband first started smoking during his service in Vietnam. (TR 62). He attempted to quit smoking at one point, but was unable to do so. (TR 62-63). The Claimant testified that her husband's cigarette intake was "not a lot." (TR 63). She stated that he eventually quit in 1993. (TR 65).

IV. Records of Treatment and Hospitalization

The record contains documentation of treatment and hospitalization, spanning March 9, 1989-October 13, 2002. (DX 19). It documents treatment for a variety of conditions, including rheumatoid arthritis, pleural effusion, shortness of breath, CWP, COPD, bronchiectasis, coronary artery disease, dyspnea, and cor pulmonale. These records contain the results of numerous objective tests. They include chest X-rays from 1991-2002, which document pleural effusion, pleural fibrosis, pleural thickening, COPD, interstitial fibrosis, granulomatous disease, and pulmonary emphysema. Also included are the results three PFS tests, dated February 16, 1999, February 21, 1995, and June 10, 1998, which document very severe obstructive lung disease, obstructive airway capacity, moderate restrictive ventilatory abnormality, and severely deteriorated diffusion capacity. The records include the results of a June 10, 1998 cardiopulmonary stress test, which revealed interstitial lung disease related to rheumatoid lung disease. Additionally, a September 30, 2002 CT scan revealed a lesion at the right lung.

These records also contain the prosector's autopsy report, dated October 21, 2002. The report lists the following as the final anatomic diagnoses:

- (1) Bronchiopneumonia;
- (2) Fibrocalcific granulomata;
- (3) Atherosclerosis with calcification;
- (4) Remote myocardial infarction of the left ventricle;
- (5) No gross abnormalities of the brain;
- (6) No gross or microscopic evidence of CWP; and
- (7) Chronic active gastritis of the stomach.

V. Death Certificate

The death certificate lists the date of death as October 20, 2002. (DX 14). The cause of death was listed as COPD. Cor pulmonale was listed as another serious condition contributing to

death but not resulting in the underlying cause COPD. An autopsy was performed, as detailed above.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

A. Entitlement to Benefits³³

Part 718 applies to survivors' claims which are filed on or after April 1, 1980. 20 C.F.R. § 718.1. There are four possible methods for analyzing evidence in a survivor's claim under Part 718: (1) Where the survivor's claim is filed prior to January 1, 1982; (2) Where the survivor's claim is filed prior to January 1, 1982 and there is no living miner's claim or the miner is not found entitled to benefits as a result of a living miner's claim filed prior to January 1, 1982; (3) Where the survivor's claim is filed after January 1, 1982 and the miner was found entitled to benefits as the result of a living miner's claim filed prior to January 1, 1982; and (4) Where the survivor's claim is filed on or after January 1, 1982 where there is no living miner's claim filed prior to January 1, 1982 or the miner is found not entitled to benefits as a result of a living miner's claim filed prior to January 1, 1982. The fourth, § 718.205(c) applies to this claim.³⁴

The Regulations provide that a survivor is entitled to benefits only where the miner *died due to pneumoconiosis*. 20 C.F.R. § 718.205(a). As a result, the survivor of a miner who was totally disabled due to pneumoconiosis at the time of death but died due to an unrelated cause, is not entitled to benefits. 20 C.F.R. § 718.205(c). Under § 718.205(c)(4), if the principal cause of death is a traumatic injury or a medical condition unrelated to pneumoconiosis, the survivor is not entitled to benefits unless the evidence establishes that pneumoconiosis was a substantially contributing cause of the death.

The Regulations now provide, and the Board has held, that in a Part 718 survivor's claim, the Administrative Law Judge must make a threshold determination as to the existence of pneumoconiosis arising out of coal mine employment, under 20 C.F.R. § 718.202(a), prior to considering whether the miner's death was due to the disease under § 718.205. 20 C.F.R. § 718.205(a); *Trumbo v. Reading Anthracite Co.*, 17 B.L.R. 1-85 (1993).

B. Existence of Pneumoconiosis

Pneumoconiosis is defined as a "chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment." 30 U.S.C. § 902(b); 20 C.F.R. § 718.201. The definition is not confined to "coal workers' pneumoconiosis," but also includes other diseases arising out of coal mine employment, such as anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, progressive massive

³³ Under *Shupe v. Director, OWCP*, 12 B.L.R. 1-200 (1998) (en banc), the location of a miner's last coal mine employment is determinative of the circuit court's jurisdiction. Here, because the miner's last coal mine employment occurred in West Virginia, Fourth Circuit law controls.

³⁴ The survivor is not entitled to the use of lay evidence, or the presumptions at §§ 718.303 and 718.305 to aid in establishing entitlement to survivor's benefits. A survivor is automatically entitled to benefits only where the miner was found entitled to benefits as a result of a claim filed prior to January 1, 1982. However, a survivor is not automatically entitled to such benefits under a claim filed on or after January 1, 1982 or where no miner's claim was filed prior to January 1, 1982. *Neely v. Director, OWCP*, 11 B.L.R. § 1-85 (1988).

fibrosis, silicosis, or silicotuberculosis. 20 C.F.R. § 718.201.³⁵ This term “arising out of coal mine employment” is defined as including “any chronic pulmonary disease resulting in respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment.” Therefore, this broad definition “effectively allows for the compensation of miners suffering from a variety of respiratory problems that may bear a relationship to their employment in the coal mines.” *Robinson v. Pickands Mather & Co./Leslie Coal Co. & Director, OWCP*, , 914 F.2d 35 (4th Cir. 1990) (citing, *Rose v. Clinchfield Coal Co.*, 614 F.2d 936, 938 (4th Cir. 1980)).

Thus, asthma, asthmatic bronchitis, or emphysema may fall under the regulatory definition of pneumoconiosis if they are related to coal dust exposure. *Robinson v. Director, OWCP*, 3 B.L.R. 1-798.7 (1981); *Tokarcik v. Consolidation Coal Co.*, 6 B.L.R. 1-666 (1983). Likewise, chronic obstructive pulmonary disease may be encompassed within the legal definition of pneumoconiosis. *Warth v. S. Ohio Coal Co.*, 60 F.3d 173 (4th Cir. 1995) and see § 718.201(a)(2)(2001). Moreover, the Board has adopted the Director’s position to hold that “a transient aggravation of a non-occupational pulmonary condition is insufficient to establish pneumoconiosis as defined at Section 718.201.” *Henley v. Cowan and Co.*, 21 B.L.R. 1-148, BRB No. 98-1114 BLA (May 11, 1999).

The claimant has the burden of proving the existence of pneumoconiosis. The Regulations provide the means of establishing the existence of pneumoconiosis by: (1) a chest X-ray meeting the criteria set forth in 20 C.F.R. § 718.202(a)(1); (2) a biopsy or autopsy conducted and reported in compliance with 20 C.F.R. § 718.106; (3) application of the irrebuttable presumption for “complicated pneumoconiosis” found in 20 C.F.R. § 718.304; or (4) a determination of the existence of pneumoconiosis made by a physician exercising sound judgment, based upon certain clinical data and medical and work histories, and supported by a reasoned medical opinion. 20 C.F.R. § 718.202(a)(4).

³⁵ Regulatory amendments, effective January 19, 2001, state:

(a) For the purpose of the Act, “pneumoconiosis” means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. This definition includes both medical, or “clinical”, pneumoconiosis and statutory, or “legal”, pneumoconiosis.

(1) Clinical Pneumoconiosis. “Clinical pneumoconiosis” consists of those diseases recognized by the medical community as pneumoconiosis, i.e., the conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. This definition includes, but is not limited to, coal workers’ pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis or silicotuberculosis, arising out of coal mine employment.

(2) Legal Pneumoconiosis. “Legal pneumoconiosis” includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This definition includes, but is not limited to, any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment.

(b) For purposes of this section, a disease “arising out of coal mine employment” includes any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment.

(c) For purposes of this definition, “pneumoconiosis” is recognized as a latent and progressive disease which may first become detectable only after the cessation of coal mine dust exposure. (Emphasis added).

In *Island Creek Coal Co. v. Compton*, 211 F.3d 203(4th Cir. 2000), the Fourth Circuit held that the administrative law judge must weigh all evidence together under 20 C.F.R. § 718.202(a) to determine whether the miner suffered from coal workers' pneumoconiosis. This is contrary to the Board's view that an administrative law judge may weigh the evidence under each subsection separately, i.e. X-ray evidence at § 718.202(a)(1) is weighed apart from the medical opinion evidence at § 718.202(a)(4). In so holding, the court cited to the Third Circuit's decision in *Penn Allegheny Coal Co. v. Williams*, 114 F.3d 22, 24-25 (3d Cir. 1997) which requires the same analysis.

In this case, upon weighing the medical evidence together, the Claimant has established that the miner had pneumoconiosis.

I note at the outset that the chest X-ray evidence does not support the existence of pneumoconiosis. The existence of pneumoconiosis may be established by chest X-rays classified as category 1, 2, 3, A, B, or C according to the ILO-U/C International Classification of Radiographs. A chest X-ray classified as category 0, including subcategories of 0/-, 0/0, 0/1, does not constitute evidence of pneumoconiosis. 20 C.F.R. § 718.102(b).³⁶

In this case, although the Dr. Alexander predicated his conclusion that the miner had pneumoconiosis in part upon the X-ray readings admitted as CX 4, he did not provide individual readings specific to those X-rays. To that end, the record does not contain readings of those X-rays classified according to § 718.102(b). Therefore, these readings are accorded diminished weight in supporting the existence of pneumoconiosis. Similarly, although many of the X-ray readings contained in the hospitalization records report the presence of CWP, they too were not classified according to this system and their conclusions are also accorded diminished weight. In contrast, the record contains four negative X-ray readings classified in accordance with the Regulations. As such, those readings are entitled to the most weight. Because those readings do not support the existence of pneumoconiosis, the chest X-ray evidence as a whole does not support the existence of pneumoconiosis.

Similarly, the CT scan evidence also does not support the existence of pneumoconiosis. Dr. Alexander concluded that the two CT scans revealed the presence of several large opacities and masses but he did not opine that they were reflective of pneumoconiosis. (CX 6). Similarly, the readings of Drs. Wheeler and Wiot also do not include any findings of CWP. Therefore, the CT evidence as a whole does not support the existence of pneumoconiosis.

Conversely, the autopsy evidence supports the existence of pneumoconiosis. As stated, autopsy report evidence that complies with § 718.106 may be the basis for finding the existence of pneumoconiosis. 20 C.F.R. § 718.202(a). § 718.106 requires a report of autopsy to include a detailed gross macroscopic and microscopic description of the lungs or visualized portion of the lungs. The Board has held that such autopsy evidence "is the most reliable evidence of the existence of pneumoconiosis." *Terlip v. Director, OWCP*, 8 B.L.R. 1-363 (1985).

³⁶ In cases where X-ray reports are in conflict, consideration may be given to the qualifications of the physicians interpreting the X-rays. *Dixon v. N. Camp. Coal Co.*, 8 B.L.R. 1-344 (1985). In this case, however, this point is not determinative as the X-rays readings proffered by the parties were read by equally qualified physicians.

In this case, of the five autopsy reports admitted in the record, four report the existence of pneumoconiosis. Dr. Kahn opined that the miner had simple CWP. (DX 21 & 18). Dr. Green reported simple CWP, dust-induced emphysema, and coal dust-induced progressive massive fibrosis. (CX 3). Dr. Bush found “lesions of pneumoconiosis.” (EX 1). Finally, Dr. Caffrey diagnosed simple mild CWP. (EX 2A). Only the prosector’s report contained in the hospital records reported no evidence of CWP. (DX 19). Therefore, based on the consistency of the finding of pneumoconiosis among the autopsy reports, I find that the autopsy evidence as a whole supports the conclusion that the miner had pneumoconiosis.³⁷

Similarly, the medical opinion evidence also supports the conclusion that the miner had pneumoconiosis. A determination of the existence of pneumoconiosis can be made if a physician, exercising sound medical judgment, based upon certain clinical data and medical and work histories and supported by a reasoned medical opinion, finds the miner suffers or suffered from pneumoconiosis, as defined in § 718.201, notwithstanding a negative X-ray. 20 C.F.R. § 718.202(a). To be credited, a medical report must be both well-documented and well-reasoned. A “documented” report sets forth the clinical findings, observations, and facts on which the doctor has based the diagnosis. *Fields v. Director, OWCP*, 10 B.L.R. 1-19 (1987). A report is “reasoned” if the documentation supports the doctor’s assessment of the miner’s health.

In this case, all five medical reports admitted in the current claim support the existence of pneumoconiosis. Moreover, all five are well-documented and well-reasoned with respect to this issue. Dr. Kahn found CWP as well as COPD, chronic bronchitis, pulmonary emphysema, and silicosis, all aggravated by CWP. (DX 21). Drs Cohen, Alexander, Bush, and Castle all found CWP to be present. (CX 2; CX 7; EX 1; EX 3). Therefore, based on this uniformity of opinion, I find that the medical opinion evidence supports the existence of pneumoconiosis.

Upon weighing the X-ray, CT scan, autopsy, and medical opinion evidence together, as required by the Fourth Circuit, I find that this evidence supports the conclusion that the miner had pneumoconiosis. The consistent strong support for this position among the autopsy reports and medical opinions outweighs the lack of support found in the CT evidence and the moderately countervailing support from the chest X-ray evidence. Therefore, I find that the Claimant has met the burden of establishing that the miner had pneumoconiosis.

I note further that the type of pneumoconiosis the Claimant has established is clinical. There is evidence in the record that the miner suffered from COPD (*see e.g.* DX 14). As stated above, the Regulations allow that COPD may form the basis of legal pneumoconiosis if the evidence establishes that the condition arose out of coal mine employment.³⁸ However in this case, the evidence is insufficient to demonstrate that this COPD arose out of coal mine employment.

³⁷ It should be noted that all four physicians who found the existence of pneumoconiosis are Board-certified in pathology. The credentials of the prosector are not in the record. In case of a conflict in the autopsy evidence, the qualifications of the reporting physicians shall be considered. *See Livermore v. Amax Coal Co.*, 297 F.3d 668 (7th Cir. 2002). Here, this consideration further supports the conclusion that the miner had pneumoconiosis as all physicians with documented Board-certification in pathology have opined as much.

³⁸ *See also Richardson v. Director, OWCP*, 94 F.3d 164, 167 (4th Cir. 1996)(finding that, as a matter of law, COPD that arises out of coal mine employment constitutes legal pneumoconiosis).

The only evidence in the record that specifically links the miner's COPD to his coal mine employment is the opinion of Dr. Cohen. (CX 2).³⁹ In it, Dr. Cohen diagnosed COPD and stated that the miner's exposure to coal dust was likely a cause. Dr. Cohen reasoned, based on epidemiologic studies, that when an individual is exposed to both cigarette smoke and coal dust and develops COPD, the two exposures contribute additively to the development of the condition. However, Dr. Cohen never specifically explained how this particular miner's COPD arose out of coal dust exposure; rather, he merely relied on scientific studies that counsel toward that conclusion. This reasoning, however, is overly generalized and does not specifically focus on the miner. See *Knizner v. Bethlehem Mines Corp.*, 8 B.L.R. 1-5 (1985)(holding that an opinion based on such reasoning is insufficient to support its conclusion). Therefore, Dr. Cohen's opinion is insufficient to establish the necessary showing. Because this was the sole evidence proffered that linked COPD to coal mine employment, the Claimant has not established that the miner's COPD constituted legal pneumoconiosis. Therefore, the type of pneumoconiosis the Claimant has established is properly characterized as clinical.

The Claimant has argued that the miner's pneumoconiosis was complicated. The evidence, however, does not support this conclusion.

Under 20 C.F.R § 718.304, there is an irrebuttable presumption that a miner's death was due to pneumoconiosis or that the miner was totally disabled due to pneumoconiosis at the time of his death if he suffered from complicated pneumoconiosis. Complicated pneumoconiosis may be established if (a) an x-ray of the miner's lungs shows an opacity greater than one centimeter in diameter; (b) a biopsy or autopsy shows massive lesions in the lungs; or (c) when diagnosed by other means, the condition could reasonably be expected to reveal a result equivalent to (a) or (b). See § 718.304. The determination of whether the miner has complicated pneumoconiosis is a finding of fact, and the administrative law judge must consider and weigh all relevant evidence. *Melnick v. Consolidation Coal Co.*, 16 B.L.R. 1-31 (1991); *Maypray v. Island Creek Coal Co.*, 7 B.L.R. 10683 (1985). To that end, the administrative law judge must consider all evidence on the issue, i.e., evidence of simple and complicated pneumoconiosis, as well as evidence of no pneumoconiosis, resolve the conflicts, and make a finding of fact. *Cornelius v. Pittsburg & Midway Coal Mining Co.*, BRB No. 04-0162 BLA (Sept. 30, 2004)(unpub.).

Additionally, in recognizing that the Regulations put forth three means for establishing complicated pneumoconiosis, the Fourth Circuit requires the Administrative Law Judge to make an "equivalency determination" to ascertain whether the miner had the prescribed condition regardless of the means presented. See *E. Assoc. Coal Corp. v. Director, OWCP [Scarbro]*, 220 F.3d 250 (4th Cir. 2000); *Double B Mining Inc. v. Blankenship*, 177 F.3d 240 (4th Cir. 1999). To that end, the Fourth Circuit found that "'because prong (A) sets out an entirely objective scientific standard' - i.e. an opacity on an X-ray greater than one centimeter- x-ray evidence provides the benchmark for determining what under prong (B) is a 'massive lesion' and what under prong (C) is an equivalent result reached by other means." *Scarbro*, 220 F. 3d at 256

³⁹ To that end, I note that while the death certificate lists COPD as the cause of death, it does not state that this condition arose out of coal mine employment. (DX 14). Additionally, while Dr. Kahn diagnosed both COPD and CWP and stated that the two synergistically aggravated each other, nothing in his opinion evidences that the COPD arose out of coal mine employment. Moreover, while he found a relationship between pneumoconiosis and COPD, the CWP that he referenced is clinical pneumoconiosis. Therefore, his report offers no support toward a finding of the existence of legal pneumoconiosis. (DX 21).

(citing *Double B*, 177 F.3d at 243). With respect to autopsy evidence, it requires that the miner have “massive lesions,” which are lesions that would show on an X-ray as opacities of at least one centimeter. *See Double B*, 177 F.3d at 244.⁴⁰

Upon weighing all relevant evidence on the issue, the medical data does not support a finding of complicated pneumoconiosis. First, the X-ray evidence on the record does not substantiate such a finding. Dr. Alexander did state that the two X-rays contained in CX 4 supported his ultimate conclusion that the miner possibly had CWP to the level of category A, 2/2. However, the record does not reflect that these two X-rays admitted into evidence demonstrated opacities greater than one centimeter.⁴¹ Moreover the remaining X-ray evidence in the record also fails to demonstrate opacities of the requisite size.

There is evidence in the autopsy reports of lesions of varying sizes up to and including two centimeters. However, the only evidence toward the Fourth Circuit’s requirement of an equivalency determination is Dr. Cohen’s statement that the silicotic nodule measuring 1.2 centimeters found by Dr. Kahn “would be equivalent of category A opacities that Dr. Alexander identified radiographically.” (CX 2 at 9). This statement, however, does not establish equivalency because it is premised upon an ambiguous factual predicate, namely Dr. Alexander’s opinion.

As noted above, in assessing his overall condition Dr. Alexander stated that the miner had pneumoconiosis at least at the 1/1 level and at most at the category A, 2/2 level. (CX 7). Therefore, Dr. Alexander’s opinion is ambiguous on the matter of category A opacities.⁴² Because Dr. Cohen’s statement of the equivalency of the 1.2 centimeter lesions expressly relies upon Dr. Alexander’s finding of category A opacities, Dr. Cohen’s statement is correlatively ambiguous. Accordingly, it cannot, by itself, serve as the basis for establishing the equivalency of the lesions to the condition described in § 718.304. Moreover, because that statement is the sole proffered evidence of equivalency, the Claimant is unable to meet this requirement of establishing complicated pneumoconiosis.

Therefore, the Claimant has established that the miner had pneumoconiosis as required by the Regulations; however, the Claimant has not established that this pneumoconiosis met the requirements of § 718.304 and is therefore not entitled to the presumptions described in that subsection.

C. Cause of Pneumoconiosis

Once the miner is found to have pneumoconiosis, the Claimant must show that it arose, at least in part, out of coal mine employment. 20 C.F.R. § 718.203(a). If a miner who is suffering from pneumoconiosis was employed for ten years or more in the coal mines, there is a rebuttable

⁴⁰ Here, the Fourth Circuit mandated as much with respect to biopsy evidence. However, because autopsy and biopsy evidence are both part of prong (B) of the standard, the ruling applies to autopsy evidence as well.

⁴¹ Additionally, as will be discussed in more detail *infra*, Dr. Alexander’s ultimate conclusion on the point of complicated pneumoconiosis is equivocal and therefore entitled to diminished weight.

⁴² *See Worrell v. Consolidation Coal Co.*, 8 B.L.R. 1-158 (1986) (finding a medical opinion that does not “explicitly” offer a conclusion may be deemed ambiguous).

presumption that the pneumoconiosis arose out of such employment. 20 C.F.R. § 718.203(b). If a miner who is suffering or suffered from pneumoconiosis was employed less than ten years in the nation's coal mines, it shall be determined that such pneumoconiosis arose out of coal mine employment only if competent evidence establishes such a relationship. 20 C.F.R. § 718.203(c).

Since the miner had more than ten years of coal mine employment, the Claimant receives the rebuttable presumption that his pneumoconiosis arose out of coal mine employment. The record does not contain contrary evidence that establishes that the miner's pneumoconiosis arose out of an alternative cause.

Therefore, the Claimant has established that the miner's pneumoconiosis arose out of coal mine employment.

D. Death Due to Pneumoconiosis

Subsection 718.205(c) applies to survivors' claims filed on or after January 1, 1982 and provides that death is due to pneumoconiosis if any of the following criteria are met:

- (1) Competent medical evidence established that the miner's death was caused by pneumoconiosis; or
- (2) Pneumoconiosis was a substantially contributing cause or factor leading to the miner's death or the death was caused by complications of pneumoconiosis; or
- (3) The presumption of § 718.304 (complicated pneumoconiosis) is applicable.

There is no evidence in the record that the miner's death was "caused" by pneumoconiosis; therefore, criterion (1) does not apply. As explained above, criterion (3) also does not apply. Additionally, the evidence does not establish that the requirements of criterion (2) are met. Therefore, the Claimant has not established that the miner's death was due to pneumoconiosis.

With respect to the second criterion, the Regulations provide that pneumoconiosis is a substantially contributing cause of the miner's death if it "hastens the miner's death." 20 C.F.R. § 718.205(c). Though this provision was enacted as part of the 2001 Amendments to the Regulations, pre-Amendment Fourth Circuit case law sets forth a similar standard. Specifically, in *Shuff v. Cedar Coal Co.*, 967 F.2d 977 (4th Cir. 1992), *cert. denied*, 113 S.Ct. 969 (1993), the Fourth Circuit adopted the Director's positions that "pneumoconiosis substantially contributes to death if it serves to hasten death in any way." *Shuff*, 967 F.2d at 979.⁴³

As explained *supra*, to be credited, a medical report must be both well-documented and well-reasoned. Upon finding a report to be deficient in either area, the Administrative Law Judge may reject it entirely or accord it diminished weight in crediting its conclusions. *Clark v. Karst-Robbins Coal Co.*, 12 B.L.R. 1-149 (1989).

⁴³ In so holding, the Fourth Circuit cited, with great favor, the Third Circuit's position in *Lukosevich v. Director, OWCP*, 888 F.2d 1001 (3d Cir. 1989) that "any condition that actually hastens death is a substantially contributing cause of death." *Lukosevich*, 888 F.2d at 1006.

In this case, Drs. Kahn, Cohen, Bush, Caffrey, and Castle all offer opinions as to whether pneumoconiosis contributed to the miner's death.⁴⁴ I find Dr. Caffrey's report to be the most documented and reasoned on this issue. Moreover, I find the evidence supporting the position that the miner's death was hastened by pneumoconiosis to be largely unreasoned. Accordingly, because the burden is on the Claimant to establish by reasoned and documented evidence that pneumoconiosis substantially contributed to death, and the evidence fails to do so, the Claimant has not established this requisite element of entitlement.

Dr. Caffrey has provided the most documented and reasoned opinion as to whether pneumoconiosis played any role in the miner's death. (EX 2A). He concluded that the miner had a "mild" level of CWP and that this amount was insufficient to cause, contribute to, or hasten death. (EX 2A at 3). He supported his characterization of the degree of CWP with reference to the prosector's report, Dr. Kahn's report, and his own slide review. He supported his determination that this amount of CWP was insufficient to cause the miner's death by explaining the relative effect of CWP as compared with the effect of other conditions that he believed did play a part in the miner's death. He supported this comparison with reference to several medical treatises. Therefore, Dr. Caffrey has provided sufficient documentation and explained thoroughly how this documentation supports his conclusions.

Conversely, Dr. Kahn's opinion lacks sufficient reasoning in that he did not explain the relationship between his observations and his conclusion. (DX 21). In *Duke v. Director, OWCP*, 6 B.L.R. 1-673 (1983), the Board held that a physician's opinion may be discredited for that reason. In this case, Dr. Kahn presented properly documented and reasoned conclusions as to the existence of various pulmonary impairments, including COPD, chronic bronchitis, pulmonary emphysema, silicosis, and CWP. However, he did not explain how these conditions synergistically aggravated one another and how that resulting cumulative condition led to death. Instead, he simply stated that the presence of the various diseases made the effects of each worse and this led to death. Accordingly, he has provided no additional explanation for his conclusion that CWP and silicosis produced "effects" that contributed to death. (DX 21).

As was true in *Duke*, this rationale does not adequately explain the relationship between observation and conclusion on the issue of causation. Specifically, it provides no description of the process by which silicosis and CWP, working in concert with other impairments, led to the miner's death. Instead, it simply arrives at this conclusion. Therefore, Dr. Kahn's report is unreasoned as to cause of death and is accorded minimal weight toward that issue.

Although Dr. Bush arrives at a different conclusion than Dr. Kahn, his opinion as to the role of pneumoconiosis on death is accorded diminished weight for similar reasons. (EX 1). Dr. Bush found a "mild" degree of simple CWP and stated that the level of occupational lung disease was too limited to have played any role in death. (EX 1 at 3). He did not explain, however, why his observations concerning the degree led him to this conclusion. Therefore, as is true with Dr. Kahn's report, Dr. Bush's report fails to explain the relationship between the physician's observations and conclusions. This point is underscored when comparing Dr. Bush's report to

⁴⁴ In his report, Dr. Green offers no opinion on cause of death. (CX 3). Additionally, Dr. Alexander authored his report before the miner's death. (CX 7).

Dr. Caffrey's. Dr. Caffrey supported a similar conclusion with a comparison between CWP and other diseases and the effect that each might have, given medical literature. Conversely, Dr. Bush has merely stated that CWP did not play a role in death but interstitial disease resulting from rheumatoid disease did. Therefore, also following the Board's holding in *Duke*, Dr. Bush's report is unreasoned on this issue accorded minimal weight toward it.

Dr. Cohen's report is also accorded minimal weight on this issue as its documentation is overly generalized (CX 2). Dr. Cohen noted that miner's fatal condition was obstructive pulmonary disease. As was true in his discussion of the existence of legal pneumoconiosis, Dr. Cohen relies largely on epidemiologic studies that counsel generally toward the role of coal dust exposure in the development of COPD. He did not, however, reference specific evidence from the miner's condition in attributing this situation to this case. Thus, as was true toward the issue of legal pneumoconiosis, Dr. Cohen's support for this conclusion is overly generalized and not focused on the miner. Consistent with *Knizner*, it is accorded minimal weight as a result.

Dr. Castle's report also suffers from documentation defects as to whether pneumoconiosis played a role in the miner's death. (EX 3). On that issue, Dr. Castle stated that although CWP was present pathologically, it did not cause, contribute to, or hasten the miner's death. He supported this assertion with reference to the pathology reports. He noted that the prosector found CWP to be absent and "[v]irtually all of the other pathologists indicated it was present to a minimal degree." (EX 3 At 26). Therefore, Dr. Castle has premised his conclusion that CWP played no role in the miner's death on the degree to which the pathologists diagnosed the disease. However, his statement concerning these diagnoses is inaccurate. Drs. Bush and Caffrey did find a "mild" degree of CWP and explained how it was insufficient to impact the miner adversely. Therefore, Dr. Castle's characterization of these pathologists' as finding a "minimal" degree of CWP is accurate. Dr. Kahn, though, stated in DX 18 that the miner had "simple, mild" CWP and then diagnosed it again in DX 21 without any descriptive terms. However, Dr. Kahn went on to explain that the miner's CWP did impact the miner adversely. Therefore, it is inaccurate to ascribe the "minimal" label to Dr. Kahn's assessment of CWP. Finally, Dr. Green found "simple CWP," but made no mention of its existence at a minimal degree. Therefore, it is also inaccurate to term Dr. Green's assessment of the disease as "minimal." Accordingly, Dr. Castle was incorrect when he stated that virtually all of the reviewing pathologists indicated that CWP existed at a minimal degree. Because this point was central in supporting his conclusion that CWP played no role in the miner's death, that conclusion is accorded diminished weight.

In sum, Dr. Caffrey has provided the most documented and reasoned opinion as to whether pneumoconiosis played any relevant role in the miner's death. He concluded that the disease did not cause, contribute to, or hasten death. More importantly, however, no physician has provided a report worthy of credit that supports the position that pneumoconiosis significantly contributed to or hastened the miner's death. Therefore, the Claimant has not met the burden of establishing this element of entitlement.

CONCLUSIONS

In conclusion, the Claimant has established that the miner had pneumoconiosis, which is properly characterized as clinical. The Claimant, however, has not established that this pneumoconiosis was “complicated” and is therefore not entitled to the presumptions of § 718.304. The Claimant also established that this pneumoconiosis arose out of the miner’s coal mine employment. However, the Claimant has not established that pneumoconiosis was a substantially contributing cause or factor in the miner’s death. Therefore, the Claimant is not entitled to benefits.

ATTORNEY FEES

The award of attorney fees, under the Act, is permitted only in cases in which the Claimant is found to be entitled to the receipt of benefits. Since benefits are not awarded in this case, the Act prohibits the charging of any fee to the Claimant for representation services rendered in pursuit of the claim.

ORDER

It is ordered that the claim of S.P. for benefits under the Black Lung Benefits Act is hereby DENIED.

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RICHARD A. MORGAN
Administrative Law Judge

NOTICE OF APPEAL RIGHTS: If you are dissatisfied with the administrative law judge’s decision, you may file an appeal with the Benefits Review Board (“Board”). To be timely, your appeal must be filed with the Board within thirty (30) days from the date on which the administrative law judge’s decision is filed with the district director’s office. *See* 20 C.F.R. §§ 725.478 and 725.479. The address of the Board is: Benefits Review Board, U.S. Department of Labor, P.O. Box 37601, Washington, DC 20013-7601. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. *See* 20 C.F.R. § 802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Allen Feldman, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Ave., NW, Room N-2117, Washington, DC 20210. *See* 20 C.F.R. § 725.481.

If an appeal is not timely filed with the Board, the administrative law judge's decision becomes the final order of the Secretary of Labor pursuant to 20 C.F.R. § 725.479(a).

Notice of public hearing: By statute and regulation, black lung hearings are open to the public. 30 U.S.C. § 932(a) (incorporating 33 U.S.C. § 923(b)); 20 C.F.R. § 725.464. Under e-FOIA, final agency decisions are required to be made available via telecommunications, which under current technology is accomplished by posting on an agency web site. *See* 5 U.S.C. § 552(a)(2)(E). *See also* Privacy Act of 1974; Publication of Routine Uses, 67 Fed. Reg. 16815 (2002) (DOL/OALJ-2). It is the policy of the Department of Labor to avoid use of the Claimant's name in case-related documents that are posted to a Department of Labor web site. Thus, the final ALJ decision will be referenced by the Claimant's initials in the caption and only refer to the Claimant by the term "Claimant" in the body of the decision. If an appeal is taken to the Benefits Review Board, it will follow the same policy. This policy does not mean that the Claimant's name or the fact that the Claimant has a case pending before an ALJ is a secret.